August 8, 2016

B. Douglas Hoey
CEO, National Community Pharmacist Association
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Dear Doug,

We received your letter dated July, 18, 2016 outlining thoughtful questions and recommendations regarding Humana's 2017 Quality Pharmacy Network. We appreciate your conceptual support of value based pharmacy payment. It is clear that we share the same goal of ensuring that every patient has the best possible health outcome at the lowest possible cost.

Our approach closely aligns with Humana's value-based payment initiatives for providers, hospitals, and other health care providers. In all of our value based reimbursement programs, we seek to improve the quality of care delivered to our members by more closely aligning reimbursement with patient outcomes and moving away from a traditional fee-for-service reimbursement model. Humana's Quality Network is also modeled, in part, on the Centers for Medicare and Medicaid Services Star Ratings Program, which awards performance incentives based on a plan's performance relative to its competitors based on performance measures developed by the Pharmacy Quality Alliance (PQA) and other organizations. During the development of the program, Humana received recommendations from Pharmacy Quality Solutions (PQS), the 3rd party vendor jointly owned by PQA, in the design of the Quality Network to ensure high performing pharmacies were rewarded under the same methodology used in the CMS Stars Program for plans.

The concept of paying for value and quality can be seen in numerous value based payment models in the private and public sectors, including those implemented or proposed by CMS. For example, the shared savings concept of the CMS Accountable Care Organizations (ACOs) or the up-front discount applied in the Comprehensive Care for Joint Replacement (CJR) Model are emerging value based models developed by CMS. In fact, CMS data on Plan Star Ratings indicates that over the previous four years, less than 20% of Medicare plans have been awarded bonus payments for the highest performance level (4.5 or 5 Star overall) and less than 50% of plans have been awarded bonus payments for the 4 Star or above performance[1]. Further, in CMS' hospital star ratings program, only 2.2% of hospitals are awarded the highest performance (5 Star overall).[2] Humana is applying these same concepts to pharmacy care delivery under the same methodology that is applied to plans and hospitals to improve quality of care for seniors in the Medicare program.

[1] 2016 Star Ratings Fact Sheet accessed at https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata.html
[2] Data Brief: Evaluation of National Distributions of Overall Hospital Quality Star Ratings accessed at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-21-2.html

The highest performing pharmacies in the Quality Network, those that are above the 80th percentile of medication adherence measures, are rewarded at a higher level in order to recognize their superior performance. We operate in a similar scoring environment, as CMS has consistently set the cut points so that approximately 20% of plan contracts are 4.5 or 5 Stars. The highest performing pharmacies receive up to $6 per eligible claim, pharmacies in the 50th to 80th percentiles receive up to $2 per eligible claim, and those below the 50th percentile are not rewarded. An important component of the program design is the built in protections provided by both the exclusion of Usual and Customary claims from the $5 downside risk and pharmacies with less than 10 Humana patients in the denominator of an adherence measure receive full reconciliation of $1.66 per eligible claim (one third of $5) for each measure that does not meet the 10 patient threshold. We estimate that at least 30% of independent community pharmacies will not meet the 10 patient threshold in all three measures. This provides an important protection to those pharmacies with low Humana member mix and limited opportunities to engage in strategies to improve medication adherence.

The Proportion of Days Covered (PDC) is a member level measurement of medication adherence; the percentage of attributed adherent members is a plan/pharmacy level measurement that equals the percentage of attributed Humana members that have 80% PDC for an adherence measure; and percentile is a rank ordered distribution of plan/ pharmacy attributed adherent members – they are all different statistics. In the example cited in your letter, the "quality measurement for statins of 79% PDC" is a member level measurement that is specific to an attributed patient. This means that one specific patient is 79% adherent to their statin therapy based on PDC. However, Humana is measuring the percentage of members who are adherent at the pharmacy level. This is the percentage of total Humana members who achieve 80% or greater measurement of PDC. In this scenario, the member with a PDC of 79% would be considered non-compliant and not included in the numerator of the plan/pharmacy level measure.

NCPA references that a 79% PDC for cholesterol medication equates to 5 Star performance. To clarify, 79% is a MAPD plan 5 Star threshold and is the percentage of members who were adherent (with a PDC of 80%) for the 2014 data year. The associated PDP threshold for the 2014 data year was 83%. Of note, the Quality Network program does not just include solely MAPD members but both MAPD and PDP members combined. Utilizing only a MAPD or PDP threshold would not be methodologically sound due to membership differences between MAPD and PD plans. Clinical evidence provides support for a standard PDC threshold of 80 percent which is the threshold utilized in the Quality Network. Even if thresholds were considered, CMS thresholds are not published until 9 months after the close of the measurement year. This means that the 2015 data year thresholds will not be released until September/October of 2016. Notwithstanding, it would be methodologically unsound to use thresholds from the 2015 data year for a 2017 Quality Network program as the same methodology and performance standards are not applied to plans in this manner.

CMS does not use pre-determined threshold cut points for establishing 4 or 5 Star plan ratings for measures and moved away from pre-set 4-Star thresholds in many of the Part C and D thresholds in 2014. The CMS rationale for moving away from thresholds and moving to percentile distribution in the Stars program was the absence of plan incentive to improve beyond the established threshold. Even

before the removal, plan medication adherence measures did not have pre-determined thresholds. Just as CMS moved to a percentile distribution for plans, the Quality Network utilizes the same methodology to ensure that pharmacies are competing against their peers within the Quality Network and not competing to a threshold value or cut point. This ensures continued incentive to improve quality and specifically medication adherence in the Quality Network.

Along with participation in the Quality Network, pharmacies achieve Preferred Cost Sharing Pharmacy (PCSP) status in Humana MA-PD plans. We have heard the voices of NCPA's membership over the years related to inclusion in preferred networks alongside retail chain pharmacies. Humana has responded and takes great pride in structuring a true value based preferred network opportunity that is based on industry standards of quality performance. Inclusion in preferred networks allows community pharmacies to balance competing for patients on a level playing field. Plan premiums and cost sharing obligations are clear and transparent buying signals to beneficiaries. As a result, beneficiaries are more likely to choose low premium plans, and once in these plans, use the PCSPs that qualify for reduced cost sharing in the plan's network. This means pharmacies in the Quality network benefit from increased patient volume due to their PCSP status.

Humana explored the feasibility of reconciling Quality Network pharmacy performance on a more frequent basis. It was determined that reconciliation every 6 months was the most feasible frequency. This was primarily driven by member eligibility for the medication adherence measures. For members to be eligible for the adherence measures, they must have at least 2 fills of a medication within the measure and have a minimum of 91 days of eligibility within the measurement period. This inclusion criterion for medication adherence measures precludes monthly and quarterly frequencies of reconciliation. Additionally, in the first part of the year, PQS measures on a rolling 6 month period, which will include claims from 2 different years (i.e., February results include 2 months of present year data and 4 months of the previous year). Results from June are the first month in which all 6 months of performance is based on the 2017 plan year. Prudent methodology dictates only the measurement of 2017 data as payment is based upon claims from that year.

As CMS has discovered in many of its value based programs, pay for performance programs (P4P) within Humana's provider networks reveal that without downside risk, there is insufficient incentive to drive workflow or behavior changes that improve quality measures. We evaluated a generic dispensing rate (GDR) P4P program without downside risk to pharmacies by comparing the GDRs of participating pharmacies with a case matched control group of non-participating pharmacies. The results showed no statistically significant difference between the groups. It was concluded that market forces were driving the increase in GDR and this was occurring without any active intervention or behavior changes by participating pharmacies. Based on our previous experience, the Quality Network performance payments are structured with both upside and downside risk to ensure sufficient incentive to drive behavior change to improve the quality measurements of our network pharmacies.

Finally, the technical experts at PQS verified that it is not a possible to have a 100% score on an adherence measure and not be above the 80th percentile. Theoretically, if 25% of the pharmacies in the Quality Network had measures of 100% on a measure, they all would receive full reconciliation for each

eligible claim. Further, if there is a tie at the 80th percentile, then all pharmacies with that result would receive full reconciliation for each eligible claim.

We are encouraged that together we can work to transform pharmacy care into a model that pays for value by leveraging the clinical expertise and cognitive services for which community pharmacy has an established reputation of delivering. We look forward to partnering with community pharmacies on this endeavor.

Sincerely,

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Director, Pharmacy Quality and Patient Safety Programs
Humana Pharmacy Solutions